Valley Center – Pauma Unified School District
Authorization for Medication Administration
(Education Code Section 49423)
28751 Cole Grade Road · Valley Center, CA 92082-6599

I, the undersigned, as legal parent/guardian of ______________________ ______________
Student's Name Birthdate

Attending ______________ request that the following medicine(s) ______________
School

______________ be made available to my child at the times prescribed ______________

I understand that trained designated personnel will assist my child in taking the medicine(s) as directed by my physician. I will provide a written statement from a physician detailing method; dosage and time medication is to be taken.

I will provide the medicine(s) in the prescription container(s), which is labeled with the name of my child, the prescribing physician name, dosage of medication prescribed, and the time to be taken.

If any of the conditions in the Physician's Statement below change, a new form must be signed by the parent/guardian and the physician.

Prescription and non-prescription medications are not permitted to be taken at school without a written statement from the physician and a written statement from the parent indicating desire that the district assist the student as set forth in the physician's statement below.

This form valid only for school year 20 _______ to 20 ______

I recognize that this is a service or accommodation which the school is not legally required to perform. I agree to save and hold the district, its officers, employees or agents, harmless from all liability, suits or claims, of whatever nature of any kind, which might arise as a result of administering the medication in accord with this request.

____
Signature Date

____
Home Address

____
Work Telephone Home Telephone

Student self-administration requires a written statement from the health care provider that the student is competent to safely self-administer the medication as directed. Self-administration of medication is intended for rescue medications such as Epi Pens and asthma inhalers. Parent written request for student self-administration of medication is also required. (See back of form) By signing this form I understand I am giving permission to the District to communicate with the physician regarding this medication.

This portion to be completed by a physician licensed in the State of California

Physician's Statement

	Name of Medication	Method of Administration	Dosage	Approx. Time of Day
#1				
#2				

- Discontinue Medication #1 on ______________ and Medication #2 on ______________
- Type of Assistance for Administering Medication (Observe, measure, student self-administration) ______________
- Reason for Prescribing Medication ______________
- Precautions for Administration or Storage of Medication ______________
- Do you wish to have school personnel contact you at intervals to discuss this medication? ☐ Yes ☐ No

Please indicate: Person(s) ______________ Intervals ______________
Teacher, Resource, Nurse Daily, Weekly, Quarterly, Etc.

Printed Name of Physician	Medical License Number	Telephone Number

Signature of Physician	Date

The procedure covering prescription and non-prescription medication listed on this form will be expedited under the following conditions:

1. Only medication prescribed by the pupil's physician as being necessary to be taken by the pupil in the manner listed on this form should be brought to school. (Written parent permission also required).

2. Such medication should be taken by the pupil in accordance with instructions from the physician as listed on this form.

3. Medication brought to school to be given to the pupil according to the provisions listed on this form should be in the prescription containers which are clearly labeled by pharmacist with the name of the pupil; the name of the prescribing physician; the druggist who dispensed the medication or the manufacturer; and the dosage of medication to be taken at specified times or in specific situations, etc. (Parents may want to ask the physician for a prescription for a duplicate supply, one for home and one for school.)

4. All medication will be kept in a secure place. Any special instructions for storage or security measures of any medication should be written by the physician and give to school personnel so that such instructions can be followed.

5. Parent only shall deliver the medication and the completed form to the school health office.

6. A new medication authorization must be renewed for each school year or for any changes in medication, dosage, or time of administration during the current school year.

7. Students who demonstrate unsafe behaviors related to self-administered medications will be referred to the principal and may lose the privilege of self-administration.

For Self-Administration Medications

☐ I have instructed (name) ____in the proper way to use his/her medications. It is my professional opinion that he/she should be allowed to carry and use that medication by him/herself.

☐ It is my opinion that ____should not carry his/her medication by him/herself.

Physician Signature	Date

Parent Signature	Date